Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MILLENIUM CHIROPRACTIC
615 N OCONNOR ROAD SUITE 12
IRVING TX 75061

Respondent Name
ZURICH AMERICAN INSURANCE CO

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-11-1552-01

MFDR Date Received
JANUARY 20, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "First, regarding '230 TREATMENT NOT AUTHORIZED', the charges represented by CPT codes 99080-73, 99204, 72070, 72030, E0230, 98943, NEVER require preauthorization. Thus, this excuse for non-payment is literally fraudulent. These fees must be paid. They do NOT require pre-authorization. The CPT codes 97110-GP, 97140-59-GP, and G0238-GP do not require pre-authorization if they are administered during the first 6 visits following the date of injury. The CPT codes 97110-GP, 97140-59-GP, and G0238-GP that were administered from 02/04/10 – 02/17/20, were done so after our pre-authorization request for those services had been approved by the carrier…We contend that [Claimant] was never provided, in the appropriate manner, with any of the network documentation, notices, etc., as required by the Texas Insurance Code §§1305.005 & 1305.451. Because of that, **we are clearly owed the full amount of all of our bills submitted to Zurich for this claim**."

Amount in Dispute: $4,466.08

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 14, 2010	CPT Code 99080-73	$15.00	$15.00
January 15, 2010	CPT Code 99204	$342.00	$230.97
January 18, 2010	CPT Code 72070	$79.00	$48.60
January 18, 2010	CPT Code 73030	$71.00	$43.75
January 18, 2010	CPT Code E0230	$13.00	$11.12

January 18, 2010 January 20, 2010 January 21, 2010 January 25, 2010 January 27, 2010 January 28, 2010 February 4, 2010 February 8, 2010 February 10, 2010 February 11, 2010 February 15, 2010 February 17, 2010	CPT Code G0283-GP (X1)	$24.00/day X12 Dates = $288.00	$218.96
January 18, 2010 January 20, 2010 January 21, 2010 January 25, 2010 January 27, 2010 January 28, 2010 February 4, 2010 February 8, 2010 February 10, 2010 February 11, 2010 February 15, 2010 February 17, 2010	CPT Code 97140-59-GP (X2)	$84.00/day X12 Dates = $1,008.00	$971.76
January 18, 2010 January 20, 2010 January 21, 2010 January 25, 2010 January 27, 2010 January 28, 2010 February 4, 2010 February 8, 2010 February 10, 2010 February 11, 2010 February 15, 2010 February 17, 2010	CPT Code 97110-GP (X4)	$184.84/day X12 Dates = $2,218.08	$2,074.08
January 18, 2010 January 20, 2010 January 21, 2010 January 25, 2010 January 27, 2010 January 28, 2010 February 4, 2010 February 8, 2010 February 10, 2010 February 11, 2010 February 15, 2010 February 17, 2010	CPT Code 98943 (X1)	$36.00/day X12 Dates = $432.00	$0.00
TOTAL		$4,466.08	$3,614.24

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all-applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.

3. 28 Texas Administrative Code §134.600, effective May 2, 2006, requires preauthorization for specific treatments and services.
4. 28 Texas Administrative Code §134.204, effective March 1, 2008, sets out medical fee guidelines for workers' compensation specific services.
5. 28 Texas Administrative Code §129.5, effective July 16, 2000, sets out the procedure for reporting and billing work status reports.
6. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
7. 28 Texas Administrative Code §134.1, effective March 1, 2008, provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
8. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 230-Treatment not authorized.
   - 245-Payment pending receipt of invoice.
   - 38-Services not provided or authorized by designated (Network/Primary Care) providers.

Issues

1. Does the documentation support the respondent's denial of payment based upon out of network provider?
2. Does a preauthorization issue exist in this dispute?
3. Is the requestor entitled to reimbursement for work status report, CPT code 99080-73?
4. Is the requestor entitled to reimbursement for CPT code 99204?
5. Is the requestor entitled to reimbursement for CPT code 72070?
6. Is the requestor entitled to reimbursement for CPT code 72030?
7. Is the requestor entitled to reimbursement for CPT code E0230?
8. Is the requestor entitled to reimbursement for CPT code G0283-GP?
9. Is the requestor entitled to reimbursement for CPT code 97140-59-GP?
10. Is the requestor entitled to reimbursement for CPT code 97110-GP?
11. Is the requestor entitled to reimbursement for CPT code 98943?

Findings

1. According to the explanation of benefits, the respondent denied reimbursement for the disputed services based upon reason code "38".

   The requestor states in the position summary that "We contend that [Claimant] was never provided, in the appropriate manner, with any of the network documentation, notices, etc., as required by the Texas Insurance Code §§1305.005 & 1305.451. Because of that, **we are clearly owed the full amount of all of our bills submitted to Zurich for this claim**."

   A review of the preauthorization reports dated February 4, 2010, July 2, 2010, July 21, 2010, and August 6, 2010 finds the heading "Authorization Notice – NonNetwork". The Division finds that the respondent has not supported the denial based upon "38".
2. According to the explanation of benefits, the respondent denied reimbursement for the disputed services based upon reason code "230".
   - Per 28 Texas Administrative Code §134.600(p)(5)(A) the non-emergency healthcare that requires preauthorization includes: "(5) physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels: (A) Level I code range for Physical Medicine and Rehabilitation, but limited to:
     (i) Modalities, both supervised and constant attendance;

     (ii) Therapeutic procedures, excluding work hardening and work conditioning."

     On February 4, 2010, the respondent gave preauthorization for 6 visits of physical therapy/chiropractic services to start on February 4, 2010 and end by April 4, 2010.

     Therefore, the requestor has supported position that the disputed services rendered from February 4, 2010 through February 17, 2010 were preauthorized.

- Per 28 Texas Administrative Code §134.600(p)(5)((C) “except for the first six visits of physical or occupational therapy following the evaluation when such treatment is rendered within the first two weeks immediately following: (i) the date of injury.”

  The claimant sustained a compensable injury on January 9, 2010; therefore, disputed dates of service January 18, 2010 through January 28, 2010 did not require preauthorization per 28 Texas Administrative Code §134.600(p)(5)((C).

The Division finds that the insurance carrier’s denial based upon reason code “230” is not supported.

3. CPT code 99080-73 is defined as “Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form.”

   28 Texas Administrative Code §134.204 (l) states “The following shall apply to Work Status Reports. When billing for a Work Status Report that is not conducted as a part of the examinations outlined in subsections (i) and (j) of this section, refer to §129.5 of this title (relating to Work Status Reports).”

   28 Texas Administrative Code §129.5(i)(1) states “Notwithstanding any other provision of this title, a doctor may bill for, and a carrier shall reimburse, filing a complete Work Status Report required under this section or for providing a subsequent copy of a Work Status Report which was previously filed because the carrier, its agent, or the employer through its carrier, asks for an extra copy. The amount of reimbursement shall be $15. A doctor shall not bill in excess of $15 and shall not bill or be entitled to reimbursement for a Work Status Report which is not reimbursable under this section. Doctors are not required to submit a copy of the report being billed for with the bill if the report was previously provided. Doctors billing for Work Status Reports as permitted by this section shall do so as follows: (1) CPT code "99080" with modifier "73" shall be used when the doctor is billing for a report required under subsections (d)(1), (d)(2), and (f) of this section.”

   28 Texas Administrative Code §129.5 (d)(1) and (2) states “The doctor shall file the Work Status Report:
   (1) after the initial examination of the employee, regardless of the employee's work status;

   The disputed work status report was filed after the initial examination; therefore, per 28 Texas Administrative Code §129.5(i)(1), reimbursement of $15.00 is recommended.

4. 28 Texas Administrative Code §134.203(b)(1) states “For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules.”

   CPT code 99204 is defined as “Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.”

   Per 28 Texas Administrative Code §134.203(c)(1)(2), “To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

   (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007.”

   To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

   The 2010 DWC conversion factor for this service is 54.32.

   Review of Box 32 on the CMS-1500 the services were rendered in zip code 75061, which is located in Dallas

County. The Medicare conversion factor for Dallasl County is 36.0791.

The Medicare participating amount for code 99204 in Dallas County is $153.41.

Using the above formula, the MAR is $230.97. The respondent paid $0.00. The requestor is due the difference between the MAR and amount paid of $230.97.

5. CPT code 72070 is defined as “Radiologic examination, spine; thoracic, 2 views.”

   The Medicare participating amount for code 72070 in Dallas County is $32.28.

   Using the above formula, the MAR is $48.60. The respondent paid $0.00. The requestor is due the difference between the MAR and amount paid of $48.60.

6. CPT code 73030 is defined as “Radiologic examination, shoulder; complete, minimum of 2 views.”

   The Medicare participating amount for code 73030 in Dallas County is $29.06.

   Using the above formula, the MAR is $43.75. The respondent paid $0.00. The requestor is due the difference between the MAR and amount paid of $43.75.

7. CPT Code E0230 is defined as “Noncontact wound-warming device (temperature control unit, AC adapter and power cord) for use with warming card and wound cover.”

   Per 28 Texas Administrative Code §134.203(d) “The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows:

   (1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule.”

   The Medicare participating amount for code E0230 in Texas is $8.90.

   Therefore, $8.90 X 125% equals $11.12. The respondent paid $0.00. The requestor is due the difference between the MAR and amount paid of $11.12.

8. CPT code G0283-GP is defined as “Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care.”

   The requestor appended modifier “GP - Services [are] delivered under an outpatient physical therapy plan of care.”
   The Medicare participating amount for code G0283 in Dallas County is $12.01.

   Using the above formula, the MAR is $18.08. The respondent paid $0.00. The requestor is due the difference between the MAR and amount paid of $18.08. This amount multiplied by twelve dates = $216.96.

9. CPT code 97140-59-GP is defined as “Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes.”

   The requestor appended modifier “GP - Services [are] delivered under an outpatient physical therapy plan of care,” and “59-Distinct Procedural Service.”

   The Medicare participating amount for code 97140 in Dallas County is $26.89.

   Using the above formula, the MAR is $40.49. The requestor billed for two units; therefore, $40.49 X2 = $80.98 The respondent paid $0.00. The requestor is due the difference between the MAR and amount paid of $80.98. This amount multiplied by twelve dates = $971.76.

10. CPT code 97110-GP is defined as “Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility.”

    The requestor appended modifier “GP - Services [are] delivered under an outpatient physical therapy plan of care.”
    The Medicare participating amount for code 97110 in Dallas County is $28.70.

    Using the above formula, the MAR is $43.21. The requestor billed for four units; therefore, $43.21 X 4 = $172.84 The respondent paid $0.00. The requestor is due the difference between the MAR and amount paid of $172.84. This amount multiplied by twelve dates = $2,074.08.

11. CPT code 98943 is defined as “Chiropractic manipulative treatment (CMT); extraspinal, 1 or more regions.”

    28 Texas Administrative Code §134.203 (f) states “For products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204(f) of this title, or the Division, reimbursement shall be provided in accordance with §134.1 of this title (relating to Medical

Reimbursement). CPT code 22899 is defined as “Unlisted procedure, spine.” The requestor appended modifier -99 defined as “Multiple Modifiers.” A review of the medical bill does not support the use of modifier 99.

CPT code 98943 does not have a relative value unit assigned; therefore, reimbursement shall be provided in accordance with 28 Texas Administrative Code §134.1.

28 Texas Administrative Code §134.1, states that “Fair and reasonable reimbursement shall: (1) be consistent with the criteria of Labor Code §413.011; (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available.”

Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual’s behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

28 Texas Administrative Code §133.307(g)(3)(D), requires the requestor to provide “documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement.” Review of the submitted documentation finds that:

- The requestor asks to be reimbursed the full amount of the billed charges in support of which the requestor states “These fees must be paid. They do NOT require pre-authorization.”
- The requestor does not discuss or explain how reimbursement of $36.00 for code 98943 is a fair and reasonable reimbursement.
- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Payment cannot be recommended for CPT code 98943.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $3,614.24.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $3,614.24 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	2/26/2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.